REQUEST TO RESTRICT MEDICAL OR DENTAL INFORMATION

The purpose of this form is to provide the patient with a means to request a restriction on the use and disclosure of his/her protected health information. Guidelines regarding use of this form are contained in DOD Regulation 6025.18-R.

This form will not be used to request restrictions on the use or disclosure of any alcohol or drug abuse patient information from medical records or from records of an alcohol or drug abuse treatment program. For requests related to use and disclosure of alcohol or drug abuse patient information, see 42 USC section 290dd, 42 CFR Part 2. (Pursuant to the Privacy Act of 1974, 5 USC section 552a)

PATIENT DATA

Name (Last, First, MI)	Date of Birth (YYYYMMDD)	Patient Social Security/Identification Number

Period of treatment (YYYYMMDD - YYYYMMDD)

Type of Treatment ☐ Outpatient ☐ Inpatient ☐ Both

RESTRICTIONS

REQUEST (RESTRICTION) IS DIRECTED TO THE TRICARE HEALTH PLAN OR FOLLOWING PHYSICIAN/ FACILITY:

_____
Name of Physician, MTF, or DTF

_____
Address City State Zip

_____
Phone Fax

PURPOSE OF RESTRICTION (Optional):
_____
_____
_____
_____

Requested Dates of Restriction:
Start Date (YYYYMMDD)_____
End Date (YYYYMMDD)_____

SPECIFY MEDICAL INFORMATION TO BE RESTRICTED (use reverse side for additional space):

PLEASE READ AND SIGN BELOW

I understand that:

1. The MTF/DTF/TRICARE Health Plan is not required to approve this request for restriction.
2. If approved by an MTF/DTF, this restriction only applies to the MTF/DTF that granted approval. It is not transferable to other providers, MTFs, DTFs.
3. If approved, the MTF/DTF/TRICARE Health Plan is not required to abide by this restriction if the health information is needed to provide emergency treatment or services.
4. If approved, this restriction does not prevent me from having access to my own health information or to an accounting of how my health information has been used.
5. If this request for restriction is approved, the MTF/DTF/TRICARE Health Plan still has the right to use or disclose my health information under the following circumstances: judicial and administrative purposes; health oversight; research; law enforcement; public health; to avert a serious threat to health and safety; organ, eye, or tissue donation; decedents; Worker's Compensation; victims of abuse, neglect, or domestic violence; specialized government functions; and required by law.
6. Once approved, this restriction can be terminated under the following circumstances:
   a. If I request the termination in writing.
   b. If I request the termination orally and it is documented by the MTF/DTF.
   c. If the MTF/DTF/TRICARE Health Plan informs me that it has decided to terminate the restriction. In this situation, the termination only applies to the health information created or received after the termination is in effect.

Signature of Patient/Guardian	Relationship to Patient (if applicable)	Date (YYYYMMDD)

FOR PROVIDER / FACILITY USE ONLY: ☐ Request Approved ☐ Request is Disapproved ☐ Response attached

_____
Signature of Approving Official

Imprint of Patient Identification Plate When Available	Sponsor Name: FMP/Sponsor SSN Sponsor Rank: Branch of Service: Phone Number:

(Continued) Use this space to specify medical information to be restricted: